



ALABAMA DERMATOLOGY ASSOCIATES
MEDICAL | SURGICAL | COSMETIC

PATIENT INFORMATION

Date: _____

Please Print

Complete Name: _____ Birthdate: _____
First Middle Last Month Day Year

Mailing Address: _____ SS#: _____
Street City State Zip

Email: _____ Place of Employment: _____

Telephone #'s (including area code): _____
Home Cell Other

Which should we call first? Home Cell Other May we leave a voicemail or text message? Yes No

(If Student) Home Address: _____ City: _____ State: _____ Zip: _____

Person Responsible for Bill: _____ Relation to Patient: _____

Mailing Address of Person Responsible: _____

Place of Employment of Person Responsible: _____

Primary Care Physician: _____ Referring Physician: _____

Gender: Female Male Marital Status: Single Married Divorced Widowed or Widower

Ancestry: African Asian White Other: _____ Are you Hispanic or Latino? Yes No

Preferred Language: English Spanish Other: _____

Pharmacy Name, Street and City: _____

Medical History: (Please list all your medical problems or conditions)

Current Medications: (including vitamins, supplements, herbals, over-the-counter, aspirin, and those for skin conditions)

Surgeries: _____

Do you have any MEDICATION ALLERGIES?

YES NO If yes, please list: _____

Skin Disease(s): _____

Alcohol? None Less than 1 drink/day

1-2 drinks/day 3 or more drinks/day

Do you wear sunscreen? Yes No SPF? _____

Do you tan in a tanning bed? Yes No

Do you have a family history of melanoma?

Yes No Which relative? _____

Tobacco? Current every day smoker

Current some day smoker Former smoker

Never smoker